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## **Abstract**

**Background:** The life of older mentally ill offenders is often characterized by successive periods of detention in correctional facilities, admissions to psychiatric services and unsuccessful attempts to live independently.

**Methods:** Eight personal stories revealed through in-depth interviews were analyzed in the phenomenological research tradition.

**Results:** The results of the study reveal that older mentally ill offenders had more positive and less negative experiences in prison settings when compared to other institutional care settings. Independent living, unsurprisingly, is favored the most. This may be due to the fact that the latter option fosters personal competence, feelings of being useful, personal choices and communication and contact with the 'outside' world.

**Conclusion:** More research into how these concepts could be used to support older mentally ill offenders needs consideration and may lead to combining risk assessment with improving well-being in order to stimulate offender rehabilitation, even in later life.

## **Treatment and control: A qualitative study of older mentally ill offenders' perceptions on their detention and care trajectory.**

### **Introduction**

Most Western European countries apply the legal principle of providing mandatory psychiatric treatment instead of incarceration for mentally ill offenders that have been judged as not being legally responsible for their offences (Melamed, 2010). However, the provision of mandatory forensic psychiatric care is problematic in several respects. Dressing & Salize (2009) questioned experts in 24 European countries about the mental health care in prison as well as about the availability of the subsequent forensic-psychiatric care pathways that were provided for mentally ill offenders. In two-thirds of the countries shortcomings were revealed, including a lack of provision of psychotherapeutic treatment programs, a lack of both sufficient beds for psychiatric in-patient settings and appropriately trained staff, insufficient mental state screening examinations, deficient or absent psychiatric aftercare, underfunding and poor integration with the general health systems.

### *Rehabilitation of offenders*

Recent publications on the rehabilitation of (mentally ill) offenders underscore the importance of targeting the treatment and care of such offenders, rather than (only) focusing on risk reduction or punishment. The Good Lives Model (GLM), a strengths-based rehabilitation model developed by Ward et al. (Ward & Brown, 2004; Ward, Yates, & Willis, 2012) is a promising theoretical framework in this respect, because of its focus on the offender's personal hopes, quality of life and well-being, while at the same time addressing the offender's criminogenic needs (Ward et al., 2012). The GLM starts from the assumption that if offenders can lead valued lives, in which they can pursue their goals and dreams in non-criminal ways, the risk on recidivism decreases. Therefore, offenders should be supported in how to live a "good" life, addressing both their personal strengths as well as environmental conditions. From

that perspective, the GLM focuses on underscoring the human agency of offenders, while at the same time considering the importance of ensuring safe environments and communities. How to ensure that offenders can lead a fulfilling life, while simultaneously respecting the safety of the community they live in, is an important question (Willis, Yates, Gannon, & Ward, 2013).

*Aging in older mentally ill offenders: some facts and characteristics*

Promoting the living of a 'valued' life among older mentally ill offenders (OMIOs) is made more complex because of the interplay between their offending behavior and the more usual physical, mental and social needs that are associated with the aging process. Although most research focuses on the situation in the United States (Fellner, 2012), aging in mentally ill offenders is currently recognized as a global problem (Aday, 2013). Contrary to their incarcerated peers who are not subject of mandatory forensic psychiatric care, the characteristics of OMIOs have been studied to a much lesser extent. Moreover, the available studies are characterized by some conceptual and methodological difficulties. The first problem involves the definition of a distinctive age threshold. Equally, whether and to what extent the assumption of accelerated aging should be taken into consideration seems a recurring problem (Yorston & Taylor, 2006). Secondly, the occurrence of mental health problems may or may not be related to increasing age and often appears to be inseparable from psychiatric and criminal antecedents. In this respect, several researchers have demonstrated a high prevalence of chronic and prior mental health problems, including psychotic disorders, severe alcohol abuse, depression and co-morbidity (Coid, Fazel, & Kahtan, 2002; Farragher & O'Connor, 1995; Lewis, Fields, & Rainey, 2006; McLeod, Yorston, & Gibb, 2008; Rosner, Wiederlight, Harmon, & Cahn, 1991). Referring to a case report of Dinniss (1999a) about a demented violent murderer, it may be assumed that age-related cognitive disorders are an under-estimated element in the forensic evaluation of older offenders. Fazel & Grann (2002) and McLeod et al. (2008) reported respectively that 12.4% (n=12, age cut-off = 60) and 8.6% (n=3, age cut-off = 55) of legally insane offenders suffered from dementia. Furthermore, Curtice, Parker, Wismayer, & Tomison (2003) found dementia in 19% (n=6, age cut-off = 65) of the referrals to a

medium security ward. Compared to the imprisoned population, physical deterioration among OMIOs seems even less well researched. Nevertheless, increased vulnerability due to the prevalence of physical illnesses has been reported (Rayel, 2000) and functional impairment such as mobility and hearing problems seem to be frequently present as well (Curtice et al., 2003). O'Sullivan & Chesterman (2007) indicate that the majority of OMIOs grow older while detained within secure services and that only a minority of them committed serious offences when aged 60 years or older.

#### *Detention and care trajectories of OMIOs*

Lightbody, Gow, & Gibb (2010 p.973), described OMIOs as '*a small but significant population with heterogeneous and complex needs*' and in addition several authors have formulated recommendations towards a more tailored care approach for OMIOs (Coid et al., 2002; Curtice et al., 2003; Dinniss, 1999b; Lightbody et al., 2010; McLeod et al., 2008; O'Sullivan & Chesterman, 2007; Tomar, Treasaden, & Shah, 2005; Rayel, 2000). The need for an early mental health assessment, particularly for age-related cognitive mental disorders and physical problems is warranted. Rayel (2000) found that 59% of the OMIOs in a maximum security forensic hospital had been previously hospitalized in psychiatric institutions and analogously McLeod et al. (2008) found that this was the case for 54% of them. Therefore, it can be assumed that a considerable number of OMIOs have a long and varied trajectory of incarcerations, releases, probations and (forensic) psychiatric care. Yorston & Taylor (2006) suggested that a range of facilities in both the criminal justice and health services should be developed in order to avoid mentally ill offenders ending up in inappropriate facilities. Most studies up until now have focused on the investigation of characteristics of the OMIOs as a population. Less attention has been given to the personal perspectives of the OMIOs themselves. In this respect, Yorston and Taylor (2009) questioned older patients in an English high security hospital by open qualitative interviews in order to discover how OMIOs themselves perceived their current admission. However, to our knowledge no qualitative study has yet been undertaken with regard to OMIOs perspectives about their entire trajectory encompassing both the past as well as their current situation.

## Aims

This study aimed at analyzing OMIOs self-perceptions about their care and detention trajectory and is therefore grounded in a phenomenological approach, in which personal lived experiences of everyday life are the central focus (Finlay, 2009). Utilizing the principles of phenomenological research is consistent with the work of Schroeder (2013), who undertook a study on older mentally ill patients and argued that: *“Listening carefully to the narratives of older seriously mentally ill adults, gaining insight into their personal interactions with healthcare providers, and understanding their successes or frustrations may be a critical step in improving their health status”*. Phenomenological research seeks to describe and understand the world through the eyes of the persons involved and aims to shed a new light and to develop new insights into how situations have been thought of up until then (Johnson, 1998). Therefore, this study focuses on the care trajectories of 8 OMIOs and more specifically on the way older mentally ill offenders personally perceive these trajectories in the light of their past and future life.

It draws on findings of a study undertaken in Flanders, the Dutch speaking part of Belgium.

The research questions are the following:

- 1) What is the care trajectory of the participants like?
- 2) How did the participants experience their care trajectory?
- 3) Have the participants experienced any form of exclusion at any stage in their care trajectory?
- 4) How do the participants see their future and what are their perceptions of what could improve their situation?

As there are only a limited number of studies on care trajectories, the Flemish situation will be used as a case that is particularly interesting as many of the older offenders – due to the Belgian legal system – have ended up in prison after complex and often long-term care trajectories.

Although the sample ( $n=8$ ) is obviously small, it still falls within the recommended range for phenomenological research, that is – according to the source – estimated to be between 5 and 25 (Mason, 2010). Furthermore, the study seeks to explore a novel issue in forensic research, identifying absent knowledge in order to stimulate and guide future research. Therefore, the findings will be discussed in relation to the available international literature and implications for practice and future research possibilities with regard to older offenders in the forensic field will be presented.

## **Method**

### *Ethical considerations*

Ethical approval for the study was obtained from the Ethics committee of the University Hospital Vrije Universiteit Brussel (Free University Brussels, EC decision: B.U.N.143201112119).

### *Setting and participants*

The study was undertaken in Flanders, Belgium. Under Belgian law, the 'measure of internment' is applied to mentally ill offenders that are not considered responsible for their crimes. This is considered as a means of upholding the general principle of protecting society, while simultaneously providing appropriate psychiatric care and is similar to the treatment of mentally ill offenders in most other countries. However, Belgium applies a dichotomized model in which offenders are declared either responsible or irresponsible. According to Belgian law, the duration of internment is undefined and remains enforceable until the offender's mental health problems are resolved (Vandeveldel, Soye, Vander Beken, De Smet, Boers, & Broekaert, 2011).

The interned mentally ill population in Flanders is estimated to be 1,962 (as of February 2011, cited in Moens & Pauwelyn (2012)). Within that, 40% lived in prison, the others (60%) were either on probation; were treated in care facilities such as psychiatric hospitals; or living at home whether or not supported by domiciliary care services. Based on the results of a retrospective file study carried out in 2011 by the

first author of this article, 174 OMIOs aged 60 years and older in Flanders were identified, which corresponds to about 9% (174/1,962) of the interned population at that time.

The research population in this study comprised all interned OMIOs, aged 60 years or older who are supervised by the Commission of Social Defence (CSD) in Ghent (n=42), one of the 4 Commissions in Flanders with responsibility for the execution of the internment decision (Vandeveldt et al., 2011).

OMIOs who were unable to participate because of severe problems such as acute psychotic symptoms were excluded on the advice of the Commission. This was the case for 19 OMIOs.

The remaining 23 eligible participants were contacted in different rounds in accordance with the protocol set forth in Figure 1. In the first round, twenty OMIOs and their lawyers were approached by means of an information letter in which the goals and the procedures for the study were clearly outlined.

Unfortunately, one OMIO passed away by the time we contacted him, and another one was declared free from his measure of internment, which reduced our sample size to 21 possible participants. In this first round, ten OMIOs agreed to participate in the study. However, two of them were subsequently omitted from the study, one because of agitation at the time of the interview and another because he did not show up at the appointment twice, and chose not to participate. In an effort to increase the number of participants, another ten OMIOs were invited to participate. However, from the extended sampling frame provided by the Commission on Social Defence, only one more OMIO agreed to participate, but this participant could not be included due to the poor mental state at the time of contact. As a consequence, the number of participants remained at eight, seven of whom were male.

< Insert Figure 1 approximately here : Flowchart of participants selection protocol >

The age of participants ranged from 61 to 72 years old (mean age = 65.0 and SD = 3.8). Participation was exclusively based on a voluntary basis without any financial inducements or payment in kind and all participants signed an informed consent document.

#### *Procedure and instruments*

From September 2011 until March 2012, one-to-one interviews were conducted either at the participant's house, a care setting or in a penitentiary setting. The first two authors of this manuscript, both experienced in working with psychiatric patients and/or persons with intellectual disabilities carried out the interviews. They used an interview schedule and process that was set up according to the principles of Baarda, De Goede en Van der Meer-Middelburg (2007) whereby a topic list was used, which could be adapted in a flexible way depending on the course of the interview. The questions elicited information on the:

- *Chronological and systematic reconstruction of the entire trajectory since the first incarceration*
- *Living conditions in each place of residence*
- *Nature of mental health care and/or other support in each location*
- *Exclusion criteria for a desired place of stay during the trajectory*
- *Experiences concerning the treatment in the current place of stay and propositions for improvement*

The average duration of the interviews was 70 minutes, with a range from 39 to 128 minutes.

### *Data analysis*

Interviews were transcribed verbatim. For the processing and analysis of the interviews the eight step guidelines outlined by Zhang (Zhang & Wildemuth, 2009) were followed and the software package Nvivo 9 was used. This contributes to the efficiency, repeatability and transparency of qualitative data by helping researchers to organize, manage and code qualitative data (Hoover & Koerber, 2011; Mortelmans, 2011; Zhang & Wildemuth, 2009). Initially the research questions provided the basis for the main categories: (1) descriptions of the care or containment trajectory, (2) experiences of the care or containment trajectory, (3) perceived exclusion criteria of care and (4) suggestions for improvement. Following that, the transcripts were read holistically several times and in doing so other categories were constructed. The first two authors divided them further in subcategories until a tree-structure containing



different types of categories was achieved. During analysis, passages that were irrelevant to the research questions were subsequently excluded. This occurred in 7.13% of the total interview time. Text fragments, regardless of size, were assigned to one or more categories (coding). During the coding process itself, the tree-structure was further refined whereby every new category that emerged from the data was systematically added, either as a new main category, or as a subcategory. This cycle of categorization was repeated several times, until coherence between the categories was reached. This resulted in an adapted tree-structure and a clearly defined coding procedure. Inter-rater reliability was assessed by means of calculating the Cohen Kappa score on 130 randomly selected text fragments, which were coded separately by two of the authors and compared afterwards. Finally, after three rounds of coding and adapting the tree structure, a Cohen Kappa score of 0.72 and a degree of agreement of 97.25% was reached, which can be considered as substantial agreement (Thompson, McCaughan, Cullum, Sheldon, & Raynor (2004).

The software package Nvivo9 enables the use of counts and percentages about the coded text fragments, which may give an idea of the number of statements per category and subcategory. Although this certainly has its value with regard to the description of the sample, this study is focused more on the complex and personal narratives of the participants. The latter is more grounded in a postmodern (inter-) subjective approach in qualitative research, which aims at disclosing individual life stories (Broekaert, Van Hove, Bayliss, & D'oosterlinck, 2004; Van Hove, Gabel, De Schauwer, Mortier, Van Loon, ..., & Claes, 2012).

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## Results

### ***What does the care trajectory of the participants look like?***

At the time of the interview, three participants were residing in a penitentiary setting, one in a residential care setting and four others were living at home.

According to the number of transitions between care, (attempts to) independent living at home and detention, participants can be categorized in two groups: (1) those (n=4) who went through a long trajectory with multiple transitions (min = 9, max = 20) and (2) those who were only recently placed under the measure of internment at older age or who had experienced only a limited number of transitions (< 3) (Cf. table 1). In the first group OMIOs had been in and out of the criminal justice system for many years, most of them since their twenties. Mostly their lives are characterized by periods of being detained, being interned, being treated in psychiatric services, and living independently, and as such being free (on probation). This cycle has been repeated several times during their lives. They can be described as 'chronic internees'. The second group consists of people who have only recently been interned. Some of them had also been in prison once when they were young, but they had not been interned yet. Two of them were living in prison, waiting for an appropriate treatment. Two others lived at home, one of them receiving psychiatric daycare, and the other one receiving psychiatric follow-up, in the form of a monthly consultation.

< Insert table 1 approximately here >

### ***How did the participants experience their care trajectory?***

Experiences in each of the settings (institutional care, penitentiary setting, home) were coded as either 'positive experience' or 'negative experience'. As such the proportion of positive experiences versus the negative ones in each residential category was derived. Figure 2 shows how OMIOs experienced their stay in different settings. The specific issues that were perceived as either positive or negative in every setting will be further elaborated, using literally transcribed quotes from the interviews.

< Insert figure 2 approximately here: Proportion of positive versus negative experiences in the different places of stay >

Figure 2 presents the proportion of positive versus negative experiences in every place of residence.

Regarding institutional care, 30 experiences were shared, 6 of which were positive and 19 were

negative. Within penitentiary settings, OMIOs shared 100 experiences, of which 35 were positive and 28 were negative. Finally, 42 experiences were shared about 'home' as a place of residence, of which 24 were positive and 8 were negative. As illustrated in Figure 2, the greatest proportion of positive experiences was reported in 'home'. Contrary to what was expected, institutional care settings elicited the highest proportion of negative responses, which is especially striking if compared to both the lower proportion of negative experiences and the higher proportion of positive experiences in a penitentiary setting.

### *Institutional care*

The term institutional care comprises all settings in which OMIOs are treated on a residential basis other than prison settings – but not in normal domestic settings, e.g. a psychiatric hospital, a nursing home, a residential unit for persons with an intellectual disability, etc..

Six of the participants had lived in one or more types of institutional care facilities before, whereby they disclosed negative experiences relating to the therapeutic and occupational activities. Two participants stated that there were not enough activities. They reported boredom, inactivity and they did not experience their stay as being therapeutic.

*"I have lived here on a residential basis. There was too much spare time and too little therapy. That is not good either. After a while you start thinking: what do I have to do there? You can read the newspaper at home as well, for that you do not need to be here. Or you sleep the whole day." (D., 62 years old, home)*

Three participants reported sufficient types of therapy, but they did not experience this as being useful and in some cases it was even perceived as being childish.

*"In the psychiatric center, there was therapy, but I don't like any kind of therapy. It is as if they are dealing with little children, making drawings and paintings. The only thing I did like was the sports activity on Thursday, that was fun, but apart from that I did not like it very much. It was too much creative stuff." (H., 65 years old, home)*

Other negative experiences concerning institutional treatment settings had to do with the lack of psychological and psychiatric support available. One respondent experienced little help from the psychiatrist in the mental health hospital where he resided.

*Interviewer: "did you have conversations with the staff or with psychiatrists?" A.: "From time to time, but psychiatrists, no! Sometimes he invited me in his office, but these people pretend to have no time at all to talk to you. They do not even spend five minutes on your treatment." (A., 72 years old, home)*

Two participants complained that their compulsory medical treatment was inappropriate for their needs.

*"You know what it is like in a psychiatric hospital? They overload you with all these medications, while actually all they have to do is listening to you. It is not because you are dealing with a problem, that you have to take medication." (H., 65 years old, home).*

Only one OMIO mentioned positive experiences about institutional care facilities, referring particularly to his stay in the institution where he was living at the time of the interview.

### *Penitentiary setting*

Three participants were living in a penitentiary setting at the time of the interview. Two of them had also lived in other penitentiary settings previously. Four other participants were currently living at home or in a residential treatment setting but had also one or more experiences in penitentiary settings. Only one participant had never been in a penitentiary setting.

Unexpectedly and contrary to the experiences in residential treatment settings, OMIOs expressed more positive than negative experiences about their stay in prison. It is noteworthy that positive experiences concerned not only the activities, but also the available psychological and social support.

*"The care team was really good. In January it will be a year since we have a care team. That is meant for the mentally ill offenders. It is a doctor, a good person, I cannot say a single bad thing about him, it is a doctor who prescribes special medication, a psychiatrist. Then there is also a psychologist, mine is a very good one. She comes to see me in my cell to*

*chat and to laugh from time to time. The care team is very close to the people. They enter your room, they sit down on your bed or a chair and they talk to you. That is fantastic.” (M., 68 years old, penitentiary setting)*

Four participants were positive about the activities that were offered in prison. They appreciated the opportunity to take a variety of classes, but also to participate in leisure and sports activities.

*“There were a lot of activities and you could take classes, for example computer classes. I have two certificates, one for MS Word and one for ‘computer initiation’. [...] You can follow business management or secondary education for adults. That is interesting, actually.” (B., 62 years old, penitentiary setting)*

Being able to work in prison was highly valued by the participants. Several reasons emerged, ranging from ‘having an occupation’ to ‘earning money’ and ‘enhancing one’s self-esteem’. The sense of being valued or deriving value from work is also seen as a positive experience.

*“I also worked in prison, every morning. I did little jobs, screwing bolts and stuff like that. But you earned some money with it. I had about 50 or 60 euro’s a month. [...] I saved it for my grandchildren.” (C., 61 years old, residential treatment setting)*

*“Where I work now, we have a very good chief. It is the very first time in prison that a chief said to me: ‘friend’, and he gives me a little pat on the shoulder then, ‘you did very good today’. That moves me. If you have been in prison for so long, and you receive these words from a chief, that does something to you.” (M. 68 years old, penitentiary setting)*

Two participants were positive about the psychosocial services in one of the penitentiary settings.

*“The psycho-social services, that was supporting. That was good. They arrange practical things for you, like the paperwork with health services and so on, the things you do not know or you cannot do yourself. They had lots of contact with my wife as well.” (C., 61 years old, residential treatment setting)*

Negative experiences in a penitentiary setting mainly concerned the practical support that was offered in prison by the psychosocial service and the stay in a penitentiary setting in general.

*“The people of the psycho-social service, I hate them. Always being rejected, making unjust reports for the Commission, and having to stay in prison, just because of them.” (M., 68 years old, penitentiary setting)*

Other negative experiences were related to the activities available in prison. One person experienced this as a way of being occupied, but he did not think this was helpful. This person experienced the psychological support and treatment for mentally ill offenders in prison as being of a poor quality.

Another participant confirmed this opinion.

*Interviewer: "In that first period you were arrested, what kind of things were done? Did you have support there?" J.: "No, from time to time you have to go to the social service or to a psychologist. But that is just child's play. You are in prison, others too, and you really don't have any help there. You just sit there like a detained person. You are there between the detained ones. People talk about a psychiatric ward in prison. I have been there for several times now, and I can tell you: it does not exist." (J., 62 years old, penitentiary setting)*

According to one participant, the period in prison was a very depressing one, even to the extent that the participant considered suicide. It is striking that this quote stems from the only female participant in our study. It seems that she experienced her time in prison much worse than did her male counterparts.

Unfortunately, due to the small sample size, and the fact that she was the only female participant it is impossible to draw firm conclusions from this observation.

*"I did no longer want to eat in prison. I only wanted to die. I dreamed about being dead. I didn't see any way out. They can intern me as many times as they want, but I do not ever want to go back to prison." (H., 65 years old, penitentiary setting)*

## *Home*

Four participants were currently living in their own house. Two participants were obliged to visit a day clinic of a psychiatric center every weekday. One of them carried out semi-industrial work in a sheltered workplace, one person volunteered in a second hand shop, and one person just lived at home without any special activities. All of them were followed-up on a domiciliary care basis by a psychiatrist. Most of them saw their homes as the best place to stay. One person stated that he needed more support to restrain his alcohol abuse. The need to be under control was also stated by three other persons.

*"I lived alone in an apartment for a while, a nice one. But then, of course I bought some bottles at the groceries and I was back on the wagon. Damn it." (C., 61 years old, residential treatment setting)*

Most participants were positive about the activities offered in the community based care. OMIOs emphasized the importance of having sufficient activities, and doing something useful. However, even for those at home, creative therapies and some other forms of activities were also experienced as being too childish by three of the participants. Sports and cooking activities were positively valued, as were psycho-educational initiatives.

*"We are in groups of about eight or nine persons and then we have therapy together. We discuss the influence of using alcohol and the influence of smoking. We talk about being healthy. Last Tuesday we had a class about healthy food and burning fat. It is interesting to hear, some things I did not know yet." (D., 62 years old, home)*

When participants had too much spare time in the psychiatric center, they reported boredom, which in turn effected their motivation to continue the treatment.

Three of the four persons living at home had an unpaid job. Having a job increased the overall feeling of wellbeing for the OMIO. They liked doing their work, being able to fill their days in a useful way and taking satisfaction from it.

*"I have to work. It is volunteering, I have to do that. It is part of my conditions to be free. I love doing it. I like being there. I stay there until my retirement and if necessary I will stay even longer, until I can't do it anymore. So I have found the job for me." (J., 63 years old, home)*

All OMIOs residing at home also appreciated the domiciliary follow-up by their psychiatrist. They experienced the consultations as an important source of support.

*Experiences concerning choice and participation / 'having a voice'*

Participants frequently referred to the ability to make personal choices. Most of the statements reflected negative experiences. In two cases they referred to the time in which the decision for the measure of internment was taken. Two of them declared that their view on the matter had been fully ignored and both complained about a perceived laxity on the part of their lawyer as well. Another part of the negative experiences concerned the conditions in which participants had been given probation. Participants mentioned that they had to accept probation conditions under duress, because for them it was the only opportunity to achieve more freedom. In addition, the purpose of some of the probation conditions appeared to be unclear for them and participants often felt they had been insufficiently informed about the consequences of violation of any of these conditions. The impact of deficient information also arose when participants had been transferred from one place of residence to another.

*Interviewer: "Did you have any say in the decision to come here?" H: "Oh no, in prison Y the commission of social defense stated that there was a great lack of available places in prison Y and therefore they decided to bring me here (prison X)". (B., 62 years old, penitentiary setting)*

### *Age related experiences*

Surprisingly, only three participants, all of them residing in prison, shared experiences related to their ageing process. One of them explained that he could not engage in the same work activity anymore and recently felt obliged to find less demanding activities. Likewise, he could not participate in sports any longer. However, the participants did not consider these age related limitations as a serious problem, as they found possibilities in prison to cope with this. For example, one of them does not join sports activities anymore, but instead, he now enjoys watching sport and cheering for the other inmates. Nevertheless, one participant referred to more important consequences in a penitentiary setting as a result of physical deterioration because of age.

*"Compared to the younger fellows we need more time to change clothes, but we only get five minutes to shower. I can't do this on time. You should try it yourself: undressing, showering, drying and getting dressed within five minutes. This is*



*really impossible". Interviewer: "Do they not take account of this?" N: "No, if we shower too long, than we receive a written reprimand and thereupon we have to go to the director". (N. 65 years old, penitentiary setting)*

Also, two OMIOs, living in prison, felt that they were stuck in the penitentiary setting, because of their age. They were waiting to be moved to a mental health institute, but according to them, no appropriate place could be found for them due to their old age. One of them has grown old in prison, having been incarcerated for about 25 years. The other one was in prison for 5 years.

One OMIO, who had lived in a psychiatric hospital before, does not feel old herself, but mentions that the activities that are offered there are not appropriate for the elderly.

#### *Experiences related to the measure of internment*

Participants also gave their opinions about being the subject of measures of internment. Five participants were convinced that the imposition of such measures had been unfair and that a correctional punishment would have been better for them. Conversely, two other respondents were more positive and perceived the measure as a kind of self-protection to prevent further harm. They had even spontaneously requested extensions of the measure.

#### ***Have the participants been confronted with exclusion criteria at any stage in their care trajectory?***

Three participants never experienced problems in finding an appropriate treatment, but the other five did, with the following reasons for refusal given: (1) Bad reputation because of transgressing the house rules e.g. using drugs or alcohol. (2) Administrative difficulties hindering placements. (3) Lack of places in residential care settings. (4) Inadequate updates in reports on their current situation.

*"In prison there is a rapid turnover of staff such as social workers, psychologists and psychiatrists. Well then, you end up with somebody who doesn't know your situation at all. Despite them not knowing you at all, they write a report for the*

*Commission anyway. On what information is their report based? What do you think? On the information of previous reports of course! This keeps on going that way, again and again... That's unfair! This is a serious shortcoming and a big mistake"*  
(M. 68 years old, penitentiary setting)

Old age was experienced as an exclusion criterion from appropriate treatment by two of the participants residing in a penitentiary setting.

*"Did you know that I wrote at least a thousand letters? When I turned 60, I tried getting in to an old people's house, one tries anything to get away. But at the moment I am totally stuck."* (M., 68 years old, penitentiary setting)

### ***How do the participants see their future and which elements could improve their situation?***

Three participants in prison felt hopeless about the possibility of ever being transferred to a non-prison care facility or a home in the future. However, participants living at home had more positive expectations. They are relatively happy with their situation at present and expect to be released from all conditions in the future.

Two participants felt that people in their situation should receive more help and more treatment. It was reiterated that older people's therapies should be more age appropriate. Contrary to the current situation where psychopharmacological treatments were the primary type of intervention, participants expressed a strong preference for more psychosocial interventions, which focused on human interaction, communication and psychological support.

*"A mentally ill offender should not be locked up. They should be in a psychiatric ward. In prison Y, they do not have a psychiatric ward. There is one in prison X, but they don't do a lot over there. It always comes down to the fact these people should receive more help. As a mentally ill offender you are not punished, but even though they say you are not punished, they put you behind bars. I just don't get that. That must be changed."* (J., 63 years old, home)

## **Discussion**

In general, the results of the study reveal that OMIOs mentioned more positive and less negative experiences in penitentiary settings when compared with institutional care settings. Independent living is

the most favored option for care. This may be due to the fact that the latter option enables offenders to participate in activities (e.g. a volunteer or paid job) that foster personal competence and feelings of being useful to others. Living at home also contributes to making personal choices. Furthermore, being able to freely mingle with other people in society has a positive effect on communication and contact with the 'outside' world. Unsurprisingly many participants reported that the negative experiences of boredom, having negative feelings, such as depression and hopelessness, non-age appropriate activities, poor psychosocial support and not being adequately informed are common across settings. These findings constitute an important challenge as how to organize the care for and support of OMIOs. In the following section, the most striking results will be situated in the available international literature and overarching suggestions for future research will be presented.

### *The course of the trajectory*

In the past, four participants went through a remarkably long trajectory characterized by many transitions between care, detention and freedom and different care settings. In addition, four others only had a limited number of transitions. This is consistent with the existing categorization of criminal pathways of older offenders, which have been categorized as falling into three broad groups, namely: (1) 'long-term inmates who grow old in prison due to long sentences'; (2) 'repeat offenders who return to prison at later age' and (3) 'first time offenders', who offend in later life (Aday, 2003; Grant, 1999). However, during the interviews no information about the nature of offenses was explored. This was a deliberate choice in order to focus on current and past experiences of the care trajectories. It was assumed avoidance of discussion of the crime history would instill a climate of confidence with the participants and also to avoid any misunderstanding or suspicion.

With regard to the current place of stay, ageing was not especially perceived as a hindering factor in the lives of OMIOs. In general, classic age related problems were hardly mentioned and none of the participants in the study asked for age-related facilities. Yorston & Taylor. (2006, p. 336) previously

warned against accommodating older offenders exclusively on the grounds of chronological age, arguing that: *"Some of them like the hustle and bustle and feel they enjoy a high status in mixed-age units."* Also Sterns (as cited in Johnson, 2008, p. 4) and Gallagher (2001) confirmed that there is no 'set age' at which older offenders should be segregated into geriatric services. Often 'early aging' is used to justify the use of age cut-offs of 50 years or sometimes even lower (Aday, 2003; Price, 2006; Williams & Abrales, 2007). However, in this study no evidence was found for such accelerated physical and mental deterioration. This has been questioned by other researchers, for instance Gallagher (2001) stated that 'no empirical data could be found to support this assertion'. In addition, Oei & Bleeker (2003) mentioned that life expectancy among offenders is raising rapidly. The same authors report that the manifestation of incapacitating health problems is not a linear process, which in practice becomes only noticeable in the last stage of life. In this respect, even the oldest participant in our sample (72 years) was still relatively far away from this stage. Nevertheless, age was perceived twice as a hindering factor in order to be transferred out of prison, however it may be assumed that in both cases other complicating factors such as a high risk profile must always be taken into consideration.

#### *Prison, institutions or independent living?*

According to the participants in our study, living in a normal domiciliary home was perceived as the most desirable option and was appreciated especially if independent living was combined with outpatient care and appropriate leisure activities. The continuity of care for mentally ill offenders can only be improved if their needs are well identified prior to release, and by assisting them to engage effectively with the necessary agencies in the community (Jarrett et al., 2012). While Jarrett, Thornicroft, Forrester, Harty, Senior, King & Shaw, 2012

found a 'non-attendance' rate of 24.9% for appointments of forensic outpatients with caregivers, it must be noted that the same authors indicate that non-attendance among forensic outpatients is mainly

associated with younger clients, and as the forensic outpatients are getting older their compliance is increasing.

Negative experiences in institutional care reported by the participants in this study could be classified in three categories, namely; (1) Boredom and feelings of uselessness; (2) Age inappropriate therapies; and (3) Poor quality of psychological support offered in mental health care.

Eastwood, Frischen, Fenske, & Smilek et al. (2012, p. 482) argued that boredom can be a 'chronic and pervasive stressor with significant psychosocial consequences'. Likewise, Newell, Harries, & Ayers (2012) identified boredom as a complicating factor in psychiatric rehabilitation. Brunt & Rask (2005) showed that patients in a maximum-security forensic psychiatric hospital felt uninvolved in the life of the ward and consequently tended to invest no extra effort to improve their situation. Interestingly, according to the participants in our sample, complaints about activities in prison seemed much less than in other settings. Imprisoned participants appreciated possibilities to engage in paid work which raised their self-esteem. Not only did the salary provide the autonomy to buy things, but the interpersonal contact during the working hours prevented boredom and loneliness. Moreover, participants appreciated the support from the staff in the special care teams in prison, whereas in psychiatric wards they complained about the lack of personal attention and the perception of an excessive emphasis on psychopharmacological interventions. This corresponds to findings from Björkman, Hansson, Svensson, & Berglund (1995) who found that patients most valued the empathic qualities of staff such as: taking care, understanding, respect, devoting time to patients, and the ability to create a safe treatment environment. Least value was ascribed to characteristics of the physical environment and daily routines on the ward. Similar findings are reported by Johansson & Eklund (2003) who found that both inpatients and outpatients perceived the quality of the helping relationship as the most important factor for good care. Remarkably, in the same study, some inpatients considered their admission as a 'relief of pressure' and declared that an undemanding and structured environment helped them to escape from the high expectations and stress in the normal society. This may offer an explanation for the fact that several OMIOs in our study

appreciated their stay in prison as being characterized by a low demanding, well-structured and a predictable environment. However, in this respect some participants expressed a striking ambivalence between complaints about boredom on the one side and simultaneously a wish for a low demanding milieu on the others. However, this type of ambivalence has previously been described among psychiatric inpatients by Johansson & Eklund (2003).

## Limitations

Although qualitative research is meant to understand and interpret certain phenomena in depth, the number of eight participants in this study is small. From a phenomenological perspective, a minimum number of participants is neither defined nor required, although a minimum of six participants is mentioned in the literature as already described in the introduction of this paper (Mason, 2010).

Besides, recruitment numbers may vary significantly according to the purpose and approach of the investigation such as an ideographic versus a more general description of phenomena (Finlay, 2009). This study, based on eight ideographic narratives, aimed at describing how OMIOs perceive their care and detention trajectories. It was not the aim to be conclusive, but rather to identify topics and themes for future research, as revealed through the analysis of the narratives of the offenders themselves.

Moreover, drop-out and selection bias are difficult to avoid and are well-known problems in forensic qualitative research. Peternelj-Taylor (2005, p. 354) described these obstacles in nursing research as follows: *'Gaining access to the offender, recruitment and retention, establishing trust, and issues related to the culture of the research environment are among the many issues facing nurse researchers embarking upon a program of research with offenders'*. In addition the same author states that selection bias must be taken into consideration as a general shortcoming in research with vulnerable forensic populations. In particular in this study, it can be assumed that the most frail and vulnerable OMIOs could

not be reached for participation. However, due to privacy rules, underlying causes of drop-out could not be investigated.

Since the main purpose of this study was aimed at an analysis of personal experiences in the entire care trajectory of participants, the results also reflect experiences from the time that the OMIOs were younger than the defined threshold of 60 years. As such, most of the results must be interpreted as experiences from the past and consequently they cannot always be considered as contemporary age-related experiences. In fact, age related issues brought up spontaneously by the participants were relatively uncommon. Possibly participating OMIOs did not perceive themselves as “old”. In this respect Kleinspehn-Ammerlahn & Smith (2008) found that elderly in the general population (non-forensic) felt younger than actually was the case chronologically. On average a discrepancy of nearly 13 years was estimated.

### **Future research**

Due to the exploratory nature of this study, further research on OMIOs is definitely needed. An important objective is to further identify and elaborate the elements that need to be tackled in the current delivery of treatment and support, in order to better meet the specific needs of OMIOs. The importance of fulfilling (therapeutic) relationships, being appropriately informed so that personal choices can be made, being able to avail of age-appropriate activities and the possibility of feeling useful and being able to engage in meaningful activities (such as a job) as revealed through the offenders’ narratives, regardless of the place of residence are areas of potential future research focus. Therefore, it would be interesting to undertake a comparative analysis of the experiences of OMIOs being treated within a classic rehabilitation model, with emphasis on security, as compared to the experiences of OMIOs being treated within a more positive and strengths-based approach, such as the GLM model.

Likewise more research into the implications of community based care, combined with meaningful activities and the support of a social network, could deliver important insights to inform future

professional practice and enhance the experience of care. This responds to the need of a 'normal' - in the GLM this would be referred to as a 'good' - life and regular living circumstances that most OMIOs seem to be seeking. The development of more formal liaison arrangements between forensic care and elderly care could be beneficial in this respect (Curtice et al., 2003; Tomar, 2005; Yorston & Taylor, 2009) which underscores the necessity of more research focused on intersectional cooperation.

Furthermore, research activities to detect and assess the presence of additional vulnerability because of age related deterioration seem important (Abdul-Hamid, Johnson, Thornicroft, Holloway, & Stansfeld, 2009), as age was mentioned by some participants as an impeding factor for entry into treatment services. Furthermore, it would be interesting to investigate whether or not there are important differences in the way care trajectories are experienced by male OMIOs and by female OMIOs. Currently, little is known about this subject, and as a consequence, no or only limited distinction is being made in the way both genders are treated.

Last but not least, the finding that feeling useful, having possibilities to interact and being in charge of personal choices are important conditions in the life of OMIOs, may – in our opinion - be regarded as most important conclusion of the present study. This resembles the concepts of competence, autonomy/mastery and relatedness that were consistently found by Deci and Ryan in their seminal work on human needs and the self-determination theory (see e.g. Deci, 2008). More research into how these concepts could be targeted in supporting OMIOs offers promising possibilities for future research and may lead to combining risk assessment with improving well-being in order to stimulate offender rehabilitation, even in later life.



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Table 1

Name	Age	Gender	Legal charge*	Current residence	Current activities and treatment	Number of transitions
C.	61	M	Refused to follow treatment and got in a fight with police officers	Institution intellectual disabilities	Day activities in the institution + psychiatric follow-up	± 10**
M.	68	M	Murder, robbery	Penitentiary setting X	None	± 14**
B.	63	M	Knife fight	Penitentiary setting X	None	2
N.	67	M	Unknown	Penitentiary setting Y	None	2
D.	62	M	Unknown	Home	Daycare in psychiatric centre + psychiatric follow-up	3
J.	62	M	Stealing	Home	Volunteering, medication + psychiatric follow-up	20
H.	65	F	Vandalism, robbery	Home	Daycare in psychiatric centre, medication + psychiatric follow-up	9
A.	72	M	Unknown, fight with neighbours was the motive for internment	Home	Psychiatric follow-up	3

(\*) The 'legal charges' column is based on the narratives of the participants, not on their official files.

(\*\*) Due to complexity of the trajectory the number of transitions may be inaccurate. The figure shown is a minimal estimation.

Figure 1: Flowchart of participants selection protocol

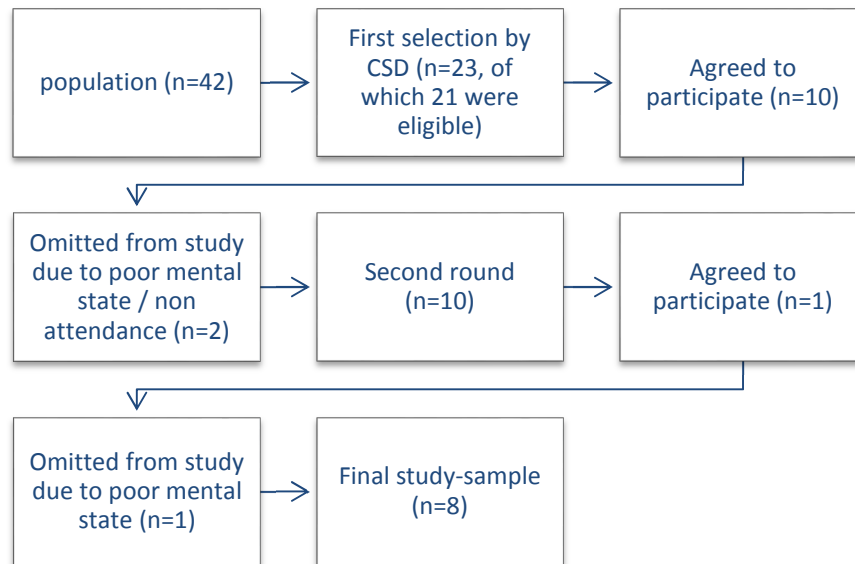
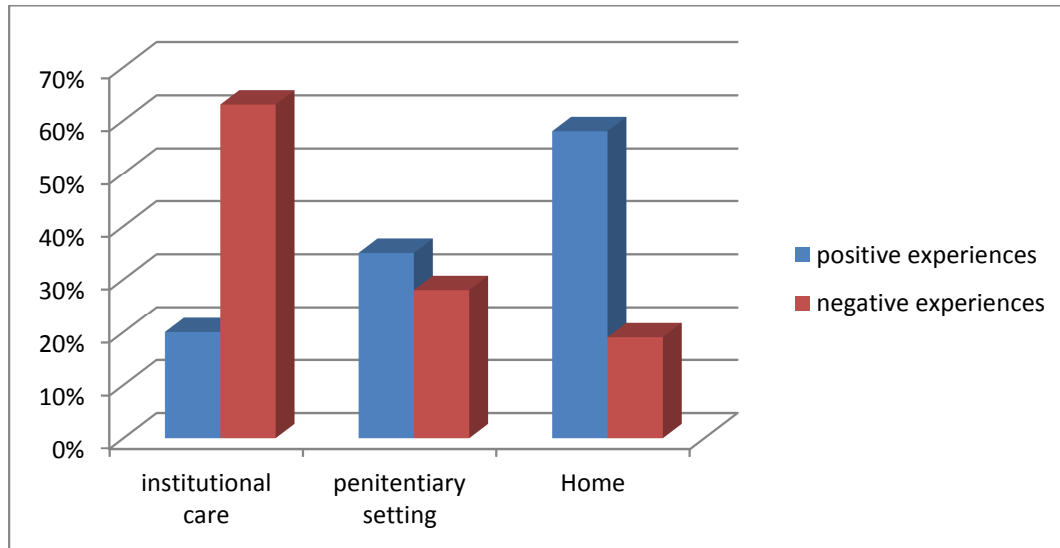




Figure 2: Proportion of positive versus negative experiences in the different places of stay



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